

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

9910-62-040890

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED OCT 19 1962

VS 300
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

OR TOWN ST. LOUIS, MISSOURI

c. FULL NAME OF (If NOT in hospital, give location)

HOSPITAL OR INSTITUTION

BARNES HOSPITAL

Length of stay in 1b

28 yrs.

Inside Limits

Yes ☐ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

b. COUNTY

c. CITY OR TOWN

St. Louis

d. STREET ADDRESS

3811A Labadie

Inside Limits

Yes ☐ No ☐

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED (Type or print)

First

Middle

Last

ESSIE

WILLIAMS

5. SEX

F

6. COLOR OR RACE

Col

7. Married ☐ Never Married ☐Widowed ☒ Divorced ☐

8. DATE OF BIRTH

6-10-1915

9. AGE (last birthday)

47

IF UNDER 1 YEAR

Months Days Hours Min.

IF UNDER 24 HR

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (City and state or country)

Terrell Texas

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Eugene Williams

13b. MOTHER'S MAIDEN NAME

Matildia Johnson

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

73 Edith Hightower

Address

3811A Labadie

18. CAUSE OF DEATH (Enter only one cause per line)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARCINOMA OF RIGHT BREAST

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

170x

INTERVAL BETWEEN ONSET AND DEATH

1 YEAR

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from JUNE 22, 1961 to OCT. 15, 1962 and last saw her alive on OCT. 15, 1962

Death occurred at 8:30 P.M. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

E. D. Vermillion, M.D.

(Degree or title)

M.D.

22b. ADDRESS

BARNES HOSPITAL

22c. DATE SIGNED

10/16/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

10-22-62

23c. NAME OF CEMETERY OR CREMATORY

Washington Park

23d. LOCATION (City, town, or county)

St. Louis Co. Mo.

(State)

24. FUNERAL DIRECTOR

Low's Funeral Home

ADDRESS

2930 Dickson

25. DATE RECD. BY LOCAL REG.

OCT 16 1962

26. REGISTRAR'S SIGNATURE

Road Smith, M.D.

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Leroy H. Penninger

Licensed Embalmer No. 4523

P. O. Address. 4251 Washington

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN** handwriting.

If this body is not embalmed, fact should be so stated above.